

(1) Perform the “limited” screening requirements described in paragraph (a) of this section.

(2) Conduct on-site visits in accordance with § 455.432.

(c) *Screening for providers designated as high categorical risk.* When the State Medicaid agency designates a provider as a “high” categorical risk, a State Medicaid agency must do both of the following:

(1) Perform the “limited” and “moderate” screening requirements described in paragraphs (a) and (b) of this section.

(2)(i) Conduct a criminal background check; and

(ii) Require the submission of a set of fingerprints in accordance with § 455.434.

(d) *Denial or termination of enrollment.* A provider, or any person with 5 percent or greater direct or indirect ownership in the provider, who is required by the State Medicaid agency or CMS to submit a set of fingerprints and fails to do so may have its—

(1) Application denied under § 455.434; or

(2) Enrollment terminated under § 455.416.

(e) *Adjustment of risk level.* The State agency must adjust the categorical risk level from “limited” or “moderate” to “high” when any of the following occurs:

(1) The State Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the OIG or another State’s Medicaid program within the previous 10 years.

(2) The State Medicaid agency or CMS in the previous 6 months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within 6 months from the date the moratorium was lifted.

§ 455.452 Other State screening methods.

Nothing in this subpart must restrict the State Medicaid agency from establishing provider screening methods in

addition to or more stringent than those required by this subpart.

§ 455.460 Application fee.

(a) Beginning on or after March 25, 2011, States must collect the applicable application fee prior to executing a provider agreement from a prospective or re-enrolling provider other than either of the following:

(1) Individual physicians or nonphysician practitioners.

(2)(i) Providers who are enrolled in either of the following:

(A) Title XVIII of the Act.

(B) Another State’s title XIX or XXI plan.

(ii) Providers that have paid the applicable application fee to—

(A) A Medicare contractor; or

(B) Another State.

(b) If the fees collected by a State agency in accordance with paragraph (a) of this section exceed the cost of the screening program, the State agency must return that portion of the fees to the Federal government.

§ 455.470 Temporary moratoria.

(a)(1) The Secretary consults with any affected State Medicaid agency regarding imposition of temporary moratoria on enrollment of new providers or provider types prior to imposition of the moratoria, in accordance with § 424.570 of this chapter.

(2) The State Medicaid agency will impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program.

(3)(i) The State Medicaid agency is not required to impose such a moratorium if the State Medicaid agency determines that imposition of a temporary moratorium would adversely affect beneficiaries’ access to medical assistance.

(ii) If a State Medicaid agency makes such a determination, the State Medicaid agency must notify the Secretary in writing.

(b)(1) A State Medicaid agency may impose temporary moratoria on enrollment of new providers, or impose numerical caps or other limits that the State Medicaid agency identifies as having a significant potential for